

03360

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LINDA Middle LEE Last AUSHERMAN				4. DATE OF DEATH Month Mar. Day 7 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1957		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Gary Ausherman				14. MOTHER'S MAIDEN NAME Juanita Klipp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Gary Ausherman Address Route #2 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis and pulmonary hypoplasia 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital diaphragmatic hernia with large and small bowel contained in left pulmonary cavity DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Indefinite						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1957 to March 7, 1957 that I last saw the deceased alive on March 7, 1957 , and that death occurred at 9:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St. Hagerstown, Maryland DATE SIGNED 3/8/57							
ACTUAL SIGNATURE B. B. Kneisley M.D.				PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 8, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LAND STATE DEPARTMENT OF HEALTH - BATHING ONE 10

BUREAU V. 3

MAR 11 1957

RECEIVED

03361

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Broadway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LARKIN</u> Last <u>BARNES</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>123-07-0087</u>	
17. INFORMANT <u>Melchora G. Barnes</u>		Address <u>111 Broadway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , to <u>March 6, 1957</u> , that I last saw the deceased alive on <u>March 5, 1957</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar. 8. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH—BANK ONE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MARRIED		WIFE		NAME		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
MARRIED		WIFE		MARY H. HARRIS		JAN 15 1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
LABORER		LABORER		HIGH SCHOOL		METHODIST		WHITE		WHITE		5' 10"		175	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH	
HEART DISEASE		NATURAL		2 WEEKS		HOSPITAL		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

MAR 11 1957

RECEIVED

03362

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		d. STREET ADDRESS 1832 Pope Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM DURWARD BOONE		4. DATE OF DEATH Month Day Year March 21 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard Pangborn Retired		10b. KIND OF BUSINESS OR INDUSTRY Libertytown Fred Co Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Boone		14. MOTHER'S MAIDEN NAME Arie Bohn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 317-09-9809	
17. INFORMANT Fanny R. Boone		Address 832 Pope Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema (c) Arteriosclerotic Cardio Vas. Disease		INTERVAL BETWEEN ONSET AND DEATH hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from on Mar 21, 1957 , to Mar 21, 1957 , that I last saw the deceased alive on Mar 21, 1957 , and that death occurred at 3 p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 136 North Potomac St. 3/22/57 ACTUAL SIGNATURE Howard N. Weeks PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffren		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Mar. 25, 1957		24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

MAR 27 1957

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 1 1957
BUREAU V. S.

03364

CERTIFICATE OF DEATH

03368

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY in 1b 5 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. STREET ADDRESS 224 E. Antietam St.,			
3. NAME OF DECEASED (Type or print) First Virginia Middle H Last Brown				4. DATE OF DEATH Month 3 Day 14 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY saleswoman		11. BIRTHPLACE (State or foreign country) Wash. Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Huron Huyett				14. MOTHER'S MAIDEN NAME Lydia Shupp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-28-6147		17. INFORMANT Address Mrs. W. F. Hopkins Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer Lung (RT upper lobe) DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.1.45 , 19____, to 3/14/57 , 19____, that I last saw the deceased alive on 3/13/57 , 19____, and that death occurred at 1.00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 3.14.57							
ACTUAL SIGNATURE Seal Young M.D.				PHYSICIAN'S NAME (Type) SEAR & YOUNG			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-16-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 16. 1957		24b. REGISTRAR'S SIGNATURE Phyllis Gowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

03365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03369

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg 85X-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In Automobile rear 260 S. Mulberry Ave</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Butts,</u> Middle <u>William Edward</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 57</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 8, 1886</u>			
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Morgan County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Butts</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Kearfoot</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Alma Ellis</u> Address <u>Martinsburg, W. Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerotic myocardial heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>grade iv with failure</u> DUE TO (c) _____ (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>- - -</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg</u> <u>W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>				ADDRESS <u>Martinsburg W. Va.</u>		24a. REC'D BY REGISTRAR <u>Mar 13 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>					

MEDICAL CERTIFICATION

2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED LAST FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		AGE YEARS MONTHS DAYS	
PLACE OF BIRTH STATE OF		DATE OF BIRTH	
OCCUPATION		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
PLACE OF DEATH STREET NO. CITY STATE		DATE OF DEATH	
TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH (To be filled by physician or medical examiner)		MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF PHYSICIAN	
OFFICIAL SEAL		OFFICIAL SEAL	

BUREAU V. 1

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03366

CERTIFICATE OF DEATH

03370

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Martin Manor Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>HARVEY</u> Middle <u>CALSMER</u> Last				4. DATE OF DEATH <u>March</u> Month <u>22</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 3, 1896</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpet Company</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Calsmer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hansen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>321-03-5289</u>		17. INFORMANT <u>Franklin H. Calsmer</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO <u>General Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Cardio Vascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>March 22, 1957</u> , to <u>March 22, 1957</u> , that I last saw the deceased alive on <u>March 22, 1957</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. A. Beachley</u> M.D.			ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>				
PHYSICIAN'S NAME (Type) <u>J. A. Beachley</u>			DATE SIGNED <u>3/22/57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/26/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elm Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Elmhurst, Illinois</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Kouzer Funeral Home</u> <u>P. Franklin Boyer</u>			ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 22/1957</u>	24b. REGISTRAR'S SIGNATURE <u>Beatrice Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		M		35		1/29/32		MOBILE, ALABAMA		ATTORNEY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
4/4/68		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		JAMES EARL RAY		JAMES EARL RAY	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		SIGNATURE OF MINISTER	
4/8/68		GREENWICH CEMETERY		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY	
DATE OF REPORT		PLACE OF REPORT		CITY		STATE		COUNTRY		SIGNATURE OF REPORTER	
4/10/68		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 26 1967

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03367

CERTIFICATE OF DEATH

03371

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 795 HAMILTON BLVD.				d. STREET ADDRESS 795 HAMILTON BLVD.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SARAH Middle JANE Last CEARFOSS		4. DATE OF DEATH Month 3 Day 7 Year 19 57					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1870	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homeduties		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) WHITE HALL, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISSAC NEEDY				14. MOTHER'S MAIDEN NAME CATHERINE GRIFFIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. EDNA C BRINTON HAGERSTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic 420.0 DUE TO heart disease, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 3, 19 57 to March 7, 19 57 , that I last saw the deceased alive on March 7, 19 57 , and that death occurred at 2:50p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Archie Robert Cohen, M.D.				ADDRESS (Street, city or town, state) Clear Spring, Md. DATE SIGNED 3/8/57			
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-9-57		22c. NAME OF CEMETERY OR CREMATORY BROADFORDING		22d. LOCATION (City, town, or county) (State) BROADFORDING MD.	
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS HAGERSTOWN, MD.				24a. REC'D BY REGISTRAR Mar 11 1957		24b. REGISTRAR'S SIGNATURE Clay H. Bowers	

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
WASHINGTON		WASHINGTON	
THE WASHINGTON BEY.		THE WASHINGTON BEY.	
DATE OF BIRTH		DATE OF DEATH	
MAY 21, 1920		MAY 21, 1920	
AGE		AGE	
34 YEARS		34 YEARS	
SEX		SEX	
FEMALE		FEMALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
HOUSEWIFE		HOUSEWIFE	
CAUSE OF DEATH		CAUSE OF DEATH	
CORONARY THROMBOSIS		CORONARY THROMBOSIS	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
WASHINGTON		WASHINGTON	
DATE OF INTERMENT		DATE OF INTERMENT	
MAY 21, 1920		MAY 21, 1920	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
[Signature]		[Signature]	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
[Signatures]		[Signatures]	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
[Signature]		[Signature]	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G213 4-11-57 et

03363

CERTIFICATE OF DEATH

Dr Binford

03372

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. STREET ADDRESS <u>130 West Washington st</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>VIRGINIA</u> Last <u>COFFMAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>57 ?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress Montgomery-Ward</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hancock Wash Co Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Coffman</u>		14. MOTHER'S MAIDEN NAME <u>Frances Colbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-9908</u>	
17. INFORMANT <u>Miss Lilla B. Coffman</u>		Address <u>130 W. Washington St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation - Pulm. embolism</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningitis</u> DUE TO (c) <u>3 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 + weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers, Thrombosis of Venous Cava</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Nov</u> , 195 <u>6</u> , to <u>31 Mar</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>31 March</u> , 195 <u>7</u> , and that death occurred at <u>3 p.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		ADDRESS (Street, city or town, state) <u>1135 Palomar ave</u>	
PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u>		DATE SIGNED <u>1 April 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

Form No. 10-57

DECEASED

DATE OF DEATH

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CAUSE OF DEATH

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APR 4 1957

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03369

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 16 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LESTER Middle NORMAN Last CONNER				4. DATE OF DEATH Month March Day 25 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby 5 1882	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor Heating & Plumbing				10b. KIND OF BUSINESS OR INDUSTRY Cedar Creek Shenandoah		11. BIRTHPLACE (State or foreign country) Virginia Co	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Conner				14. MOTHER'S MAIDEN NAME Susan M. Whittington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-3838		17. INFORMANT Mrs. Caroline M. Conner Address 13 E. Green St Funkstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Occlusion (c) 36hrs						INTERVAL BETWEEN ONSET AND DEATH 7mo 36hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 5, 1926 , to March 25, 1957 , that I last saw the deceased alive on March 24, 1957 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E.W. Ditto				ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 3/25/57			
PHYSICIAN'S NAME (Type) E.W. Ditto							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-57		22c. NAME OF CEMETERY OR CREMATORY rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mar. 29, 1957	
				24b. REGISTRAR'S SIGNATURE Chas H Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

440 *Journal of Management Inquiry* 16(4)

BUREAU V. S.

APR 1 1957

RECEIVED

03370

CERTIFICATE OF DEATH

Dr Sullivan

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>24 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>TERRY</u> Middle <u>JEAN</u> Last <u>COX</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ellis Cox Jr</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Teague</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ellis Cox Jr</u>		Address <u>Hagerstown Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>Pneumonia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Jan Burt</u> <u>Jan Burt</u> <u>Jan Burt</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>3-22</u> , 19 <u>57</u> , to <u>3-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-23</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>E. Margaret Sullivan, M.D.</u>		PHYSICIAN'S NAME (Type) <u>E. Margaret Sullivan, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blanch Bowers</u>		25. V.S. AIS (4) 15M 9/55		26. 2081222 X V3	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. RACE

4. PLACE OF BIRTH

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL

15. SIGNATURE OF INTERMENT

16. SIGNATURE OF CREMATION

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. 1

MAR 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03375
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 151 W. Washington					d. STREET ADDRESS 1 151 W. Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John First Middle Joseph Last Dachtler					4. DATE OF DEATH Month March 30 Day Year 19 57					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1914		9. AGE (In years last birthday) 42 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor			10b. KIND OF BUSINESS OR INDUSTRY electrical work			11. BIRTHPLACE (State or foreign country) Albany, N. Y.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Frederick Dachtler					14. MOTHER'S MAIDEN NAME Barabara Ferbert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. WW KK 062-12-4047		17. INFORMANT Address Mabel Dachtler, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE S. Robert Wells					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED April 1 '57
EXAMINER'S NAME (Type) S. Robert Wells, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			22d. LOCATION (City, town, or county) (State) Fort Myer, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.					24a. REC'D BY REGISTRAR Apr. 5, 1957		24b. REGISTRAR'S SIGNATURE Chas. E. Bowers			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES J. HARRINGTON		Male		35		White		Carpenter	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
Boston, Mass.		April 1, 1924		April 1, 1957		10:30 AM		Home	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
Heart Disease		Natural		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

APR 8 1957

RECEIVED

03372
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>610 Chestnut Street</u>			
3. NAME OF DECEASED (Type or print) First <u>NAPOLEON</u> Middle <u>DASHNAW</u> Last <u>DASHNAW</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tooling Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Company</u>		11. BIRTHPLACE (State or foreign country) <u>Ogdensburg, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Dashnaw</u>				14. MOTHER'S MAIDEN NAME <u>Delemma Spooner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. I</u>		17. INFORMANT <u>Mrs. Anna J. Dashnaw Hagerstown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>446 X</u> DUE TO <u>Hypertension and arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral and general arteriosclerosis</u> DUE TO (c) <u>Nephrosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Several years</u> <u>Several years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 24</u> , 19 <u>40</u> , to <u>March 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>57</u> , and that death occurred at <u>830 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown Md</u> DATE SIGNED <u>3/22/57</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>159 W. Washington St. Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Pitzer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Mar. 22, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-21		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
4-4-68		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		4-4-68		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
4-4-68		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		4-4-68		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	

BUREAU V. S.

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Dr Lusby

Reg. Dist. No. 302

03373

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Penna b. COUNTY Perry			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle ALBERT Last DOWNIN				4. DATE OF DEATH Month March Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3 1875	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Engineer				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles Downin			
14. MOTHER'S MAIDEN NAME Elizabeth Hause				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 178-03-6780 A				17. INFORMANT Edwin C. Downin Address 1390 Penna Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease with Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 yr +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 15 , 1956, to 31 Mar , 1957, that I last saw the deceased alive on 31 Mar , 1957, and that death occurred at 7:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F.F. Lusby				ADDRESS (Street, city or town, state) 2300 Potomac			
PHYSICIAN'S NAME (Type) F.F. Lusby				DATE SIGNED 1 Apr 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR Apr 2, 1957				24b. REGISTRAR'S SIGNATURE Charles H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. B.

APR 4 1957

RECEIVED

ANDREW K. GOSWAMI, M.D., BALTIMORE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

VS. A15ME(5)
5M 9/55

03374

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells 03378

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 35 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 406 West Wilson Blvd		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 406 West Wilson Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT LEE DOWNIN		4. DATE OF DEATH Month March Day 1 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silk Twister		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles McG. Downin		14. MOTHER'S MAIDEN NAME Mary E. Hause	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 314-09-6381	
17. INFORMANT Nora M. Downin		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic hypertensive myocardial 443X DUE TO heart disease Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-1-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Mar 4 1957		24b. REGISTRAR'S SIGNATURE Shatt Bowers	

ARIZONA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		12-1-22		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		BROWN		BLUE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
NONE		HEART DISEASE		SUICIDE		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
4-4-68		10:00 AM		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES					
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		CITY		STATE		COUNTRY			
JAMES EARL RAY		ATTORNEY		4-4-68		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES			

BUREAU V. S.

MAR 6 - 1957

RECEIVED

03375 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Dr Wells 03379
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cavetown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>SETH</u> Last <u>FUNK</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1957 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14 1888</u>	
9. AGE (In years last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cavetown</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Chewsville Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Funk</u>				14. MOTHER'S MAIDEN NAME <u>Ann V. Winters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 1 230-34-0837</u>		17. INFORMANT <u>M. Virginia Funk Cavetown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest: Coronary artery thrombosis (old)</u> DUE TO <u>420.1</u> <u>acute mesentery artery thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Low Spinal anesthesia --- died on operating table</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Mar 11. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 8.

MAR 13 1957

RECEIVED

03376

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Olytje Bender Gigous				4. DATE OF DEATH Month Day Year March 13 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7 1894	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min. 6 5		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Bender				14. MOTHER'S MAIDEN NAME Annie F. Delauney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. James Wynkoop Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive, arteriosclerotic C.V. disease DUE TO (c) 5 Yrs.							INTERVAL BETWEEN ONSET AND DEATH 4 mos. 3 da.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Dec. 12 1956 to 3/13/ 57 , 19____, that I last saw the deceased alive on 3/12/57 , 19____, and that death occurred at 12:15 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 3/15/57							
ACTUAL SIGNATURE Walter H. Shealy		M.D.					
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 16-57	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. Williams				ADDRESS Williamsport, Md.		24. REC'D BY REGISTRAR Mar. 16, 1957	
				24b. REGISTRAR'S SIGNATURE Phas H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. E.

MAR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03381

Reg. Dist. No. 302

03377

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>MILTON</u> Last <u>GRIMES</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 11, 1905</u>	9. AGE (In years lost birthday) yrs. <u>52</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liaison Expediter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Company</u>		11. BIRTHPLACE (State or foreign country) <u>Downsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Pearl N. Wolford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-0936</u>		17. INFORMANT <u>Maryada Mc Sherry Grimes</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>053.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Indeterminate</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>67 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal ulcer; sub-total gastrectomy and vagotomy. 3-4-57</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 20</u> , 19 <u>57</u> , to <u>March 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. T. Layman</u> M.D. <u>100 Professional Arts Bldg. 3-8-57</u> PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Mar. 12, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shast H. Bowers</u>	

BUREAU V.

MAR 14 1957

RECEIVED

03378

CERTIFICATE OF DEATH

03382

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 1 Hour			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falling Waters W. Va. RFD #1			
f. STREET ADDRESS Marlowe W. Va. 85X-3				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Myrtle Last Grove				4. DATE OF DEATH Month March Day 6 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Marlowe W. Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Landis				14. MOTHER'S MAIDEN NAME Mary Kershner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles Grove Address Falling Waters RFD #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 Day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month March Day 19 Year 19 57 Hour 19 a. m. p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3/5/57 , 19____, to 3/6/57 , 19____, that I last saw the deceased alive on 3/6/57 , 19____, and that death occurred at 9:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3/6/57							
ACTUAL SIGNATURE Ralph F. Young M.D.							
PHYSICIAN'S NAME (Type) Ralph F. Young M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8-57		22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Near Marlowe W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert S. Leaf ADDRESS 20 Williamsport, Md				24. REC'D BY REGISTRAR Mar. 7. 1957		24b. REGISTRAR'S SIGNATURE Frank Boevers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. B.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03383

03379

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1011-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash-co-Hosp</u>		d. STREET ADDRESS <u>405 Culler Ave</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL Guss</u>		4. DATE OF DEATH <u>March 17 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bacteriologist</u>	
11. BIRTHPLACE (State or foreign country) <u>ADJSS. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. d.</u>	
13. FATHER'S NAME <u>Maurice Louis Guss</u>		14. MOTHER'S MAIDEN NAME <u>Florence Estell Hyssoni</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>"Mother"</u>	
17. INFORMANT <u>405 Culler Ave. Frederick MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelactasis</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature Separation of Placenta</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-17</u> , 19 <u>57</u> , to <u>3-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>11:50P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. Woodner</u> M.D.		ADDRESS (Street, city or town, state) <u>115 King St., Hagerstown, Md</u>	
DATE SIGNED <u>Mar 18 1957</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur - Penger Funeral Home Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Frank H. Bowser</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

Washington

March 17, 1957

James W. Lee

Prostate Gland

None

BUREAU V. 1

3-17 11-10-57

3-17 11-10-57

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03384
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>TILMAN</u> <u>HAHN</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>11</u> <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER-10-1885</u>	9. AGE (In years last birthday) <u>71-5-1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE OF B.T.O.B.R.I.C.O</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BROWNSVILLE WASH. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WASHINGTON HAHN</u>				14. MOTHER'S MAIDEN NAME <u>LIDDY ANN SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>213-18-9386</u>			
17. INFORMANT <u>MRS. BERTHA M. HAHN</u>				Address <u>BROWNSVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>acute coronary artery thrombosis</u> (b) <u>(while under anesthesia on operating table)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy with bleeding</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>				20f. (City or town) (County) (State) <u>- - -</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>MARCH 14 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF THE BRETHREN CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>Mar 18 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Robert Wells</u>							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

S. Robert Wells

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3-13-57

EXAMINER'S NAME (Type)

S. Robert Wells, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MAR 20 1957

03422

CERTIFICATE OF DEATH

03385

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1000</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks 4 days</u>		d. STREET ADDRESS <u>Box 63</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>Hartle</u> Last <u>Hartle</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891 April 6, 1911</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Munson</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Saylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs. Lewis Longnecker Chewsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443 X Hypertensive</u> DUE TO <u>Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-</u> <u>193</u> , to <u>3-5</u> , <u>1957</u> , that I last saw the deceased alive on <u>Mar 4-</u> <u>1957</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. W. Kraiss</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>3/6/57</u>	
PHYSICIAN'S NAME (Type) <u>F. W. Kraiss</u>		DATE SIGNED <u>3/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fred W. Kraiss Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar. 9, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. R. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

03381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03386

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>24 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 TILGHMANTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. Co. HOSPITAL</u>				d. STREET ADDRESS <u>1 FAIRPLAY MD. R. 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORA BEILE HASSON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 19 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY-7-1886</u>		9. AGE (In years last birthday) <u>70-8-12</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES CARNES</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET DARRELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONIE</u>		17. INFORMANT Address <u>CLAUDE C. HASSON FAIRPLAY MD. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture lt. femur (closed)</u> 903.0 DUE TO <u>Pulmonary artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped on floor at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9 20 AM Mar 11 19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) (County) (State) <u>Rural- Fairplay Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 21 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR TILGHMANTON WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>Mar. 23 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Gowers</u>			

81

1

21

2

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL		MEDICAL HISTORY _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF REGISTRAR _____	
DATE _____		PLACE _____	

RECEIVED
MAR 26 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

03382

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balt.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 2715 Spinnaker Pt. Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Homer		First CLYDE Middle Hayden Last		4. DATE OF DEATH Month 3 Day 4 Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 57	IF UNDER 24 HRS. Months 4 Days 4 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY SHIP CONSTR.		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. M. HAYDEN				14. MOTHER'S MAIDEN NAME GEORGE A FORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 216-10-271		17. INFORMANT Arthur M. Hayden		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction & strangulation 011X DUE TO + perforation of ileum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculous mesenteric lymphadenitis (c) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 4 1/2 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1, 1957 , to 3-4, 1957 , that I last saw the deceased alive on 3/4, 1957 , and that death occurred at 8 A.M. from the causes and on the date stated above. 154 West Washington St., Hagerstown, Md. ADDRESS (Street, city or town, state) DATE SIGNED 3:4:57							
ACTUAL SIGNATURE John N. Hornbaker, M.D.				PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/8/57		22c. NAME OF CEMETERY OR CREMATORY ROUND OAK Churchyard		22d. LOCATION (City, town, or county) (State) Caroline Co., VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Bradley, Dundalk, Md.				24a. REC'D BY REGISTRAR MAR 8 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Washington		2. SEX Male	
3. AGE 37		4. RACE White	
5. PLACE OF BIRTH Washington Co. Maryland		6. DATE OF BIRTH 11/15/1919	
7. PLACE OF DEATH Baltimore		8. DATE OF DEATH 11/15/1957	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF WITNESSES [Signature]		14. SIGNATURE OF DECEASED [Signature]	
15. SIGNATURE OF DECEASED [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF DECEASED [Signature]	
23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]	
27. SIGNATURE OF DECEASED [Signature]		28. SIGNATURE OF DECEASED [Signature]	
29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]	
33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF DECEASED [Signature]	
35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]	
39. SIGNATURE OF DECEASED [Signature]		40. SIGNATURE OF DECEASED [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]	
45. SIGNATURE OF DECEASED [Signature]		46. SIGNATURE OF DECEASED [Signature]	
47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF DECEASED [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF DECEASED [Signature]	
53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]	
57. SIGNATURE OF DECEASED [Signature]		58. SIGNATURE OF DECEASED [Signature]	
59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]	
63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF DECEASED [Signature]	
65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]	
69. SIGNATURE OF DECEASED [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]	
75. SIGNATURE OF DECEASED [Signature]		76. SIGNATURE OF DECEASED [Signature]	
77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF DECEASED [Signature]	
83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]	
87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF DECEASED [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF DECEASED [Signature]	
95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]	
99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF DECEASED [Signature]	

BUREAU V. S.

MAR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03423

CERTIFICATE OF DEATH

03388

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountain Lock				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountain Lock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARA Middle CLEVENTINE Last HOLBRUNER				4. DATE OF DEATH Month March Day 11 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1915	
9. AGE (In years last birthday) 41 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mountain Lock, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Harry William Otzelberger			
14. MOTHER'S MAIDEN NAME Ellie Margaret Drenner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None			
16. SOCIAL SECURITY NO. 214-09-5782				17. INFORMANT Rob't. D. Holbruner Address # 1, Harpers Ferry, West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237x Brain Tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. n. Month 19 Day 19 Year 1957 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb-1 , 19 57 , to March 11 , 19 57 , that I last saw the deceased alive on March 10 , 19 57 , and that death occurred at Mountain Lock, Md. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Wilson				DATE SIGNED 3/12/57			
PHYSICIAN'S NAME (Type) G. W. Wilson				ADDRESS (Street, city or town, state) Bonabon			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/57		22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Donald Zacks				24a. REC'D BY REGISTRAR Harpers Ferry, West Va.		24b. REGISTRAR'S SIGNATURE William Dagenhart	

— — —

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G213 4-3-57 et

03383

CERTIFICATE OF DEATH

03389

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Nursing Home				e. STREET ADDRESS 704 Oak Hill Ave.			
3. NAME OF DECEASED (Type or print) First Cecelia Middle Ann Last Horst				4. DATE OF DEATH Month March Day 23 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11, 1871	
9. AGE (In years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Roxbury, Pa.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Miller				14. MOTHER'S MAIDEN NAME Lydia Franklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 000 000		17. INFORMANT Miss Mildred Brehm Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral atherosclerosis 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 51 , to March 23 , 19 57 , that I last saw the deceased alive on March 23 , 19 57 , and that death occurred at 8:10 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L L Packer Jr				ADDRESS (Street, city or town, state) 145 W Washington St Hagerstown Md			
PHYSICIAN'S NAME (Type) L L PACKER JR				DATE SIGNED 3/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mar 25 1957	
				24b. REGISTRAR'S SIGNATURE Phyllis Bowers			

WAR CAMP STATE DEPARTMENT OF HEALTH - BATHING: 10

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03424

CERTIFICATE OF DEATH

03390

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 2.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE M. HUGHES</u>				4. DATE OF DEATH Month Day Year <u>MARCH 4 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 6 1870</u>	
9. AGE (In years last birthday) <u>86-11-28</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SECURITY WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL WOLF</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET LICKTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>PAUL E. HUGHES HAGERSTOWN MD. R. 4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 2</u> , 19 <u>56</u> to <u>March 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>57</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>3/6/57</u>							
ACTUAL SIGNATURE <u>G. W. Lelan</u> M.D.				PHYSICIAN'S NAME (Type) <u>G. W. Lelan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BORIAL</u>		22b. DATE THEREOF <u>MARCH 8 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAHRNEYS CEMETERY NEAR MADLEVILLE WASH. CO. MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR DATE <u>Mar. 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bost</u>	

RECEIVED

MAR 11 1957

BUREAU V. 3

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY
DIVISION OF INVESTIGATION
CERTIFICATE OF SEARCH

SEARCHED INDEXED
SERIALIZED FILED

APR 11 1957

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells 03391

Reg. Dist. No. 302

03384

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. County Hospital				d. STREET ADDRESS 410 No Locust St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NANCY LEE HULL				4. DATE OF DEATH Month Day Year March 30 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 17 1936	
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Hills Toy Store				10b. KIND OF BUSINESS OR INDUSTRY Chewsville Wash. Co		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Keller Buhrman				14. MOTHER'S MAIDEN NAME Edith Bond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-32-6404			
17. INFORMANT Terry D. Hull				Address 410 No Locust St Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot wound thru abdomen (hemorrhage and shock) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot self with .22 rifle							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with .22 rifle			
20c. TIME OF INJURY Month, Day, Year 3-30 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Hagerstown Wash. Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4-1-57			
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/2/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR Apr 2, 1957				24b. REGISTRAR'S SIGNATURE John H. Bowers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
EDUCATION		MARRIAGE	
BIRTH		DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
RESIDENCE		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		LABORATORY TESTS	
POST-MORTEM EXAMINATION		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FINGERPRINTS		PHOTOGRAPH	
X-RAY		TOXICOLOGY	
BACTERIOLOGY		HISTOLOGY	
PATHOLOGY		ANTHROPOLOGY	
DENTAL		OTHER	

BUREAU V.S.

APR 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BP

03385

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03392

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1400 Oak Hill Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>FREDERICK</u> Middle <u>JENKINS</u> Last		4. DATE OF DEATH <u>March 25, 1957</u> Month <u>March</u> Day <u>25</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1872</u>
9. AGE (in years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Desk Clerk Dagner Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Morris Run Tioga Co Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas E. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Ann Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>170-14-2375</u>	
17. INFORMANT <u>Mrs Ruth Yeater</u>		Address <u>1400 Oak Hill Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced generalized vascular arteriosclerosis</u> <u>420.1</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (o), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar. 29, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blas H. Bowers</u>	

APR 1 1957

RECEIVED

03425

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R#2		c. LENGTH OF STAY IN 1b 50 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Wilsons		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANKLIN Last JOHNSON		4. DATE OF DEATH Month March Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Wilsons Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Johnson		14. MOTHER'S MAIDEN NAME Sarah Dittlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur B. Johnson		Address 1607 Dual Highway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic heart D. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cordis - Sclerosis D.		INTERVAL BETWEEN ONSET AND DEATH 1917-1958	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Md.	
21. I certify that I attended the deceased from March 26, 1957 , to March 26, 1957 , that I last saw the deceased alive on March 26, 1957 , and that death occurred at 4 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Novenstein		ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED 3-27-57	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/57	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery near Clear Spring Wash Co Md		22d. LOCATION (City, town, or county) (State) Washington Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR MAR 28 1957		24b. REGISTRAR'S SIGNATURE Emma McElroy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5'10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		HEART DISEASE		BLOOD POISONING		NO		NO	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. 3

MAR 28 1957

RECEIVED

Andrew A. Gollan, Registrar

CERTIFICATE OF DEATH

03394

Reg. Dist. No. 302

03386

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE</u> <u>1</u> <u>KEEDY</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> - <u>6</u> <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY-14-1864</u>	
9. AGE (In years last birthday) <u>93-1-22</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>ROHRERSVILLE WASH. CO. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN A. MULLENDORF</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN BEALER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. ERNEST YOUNG ROHRERSVILLE MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>57</u> , to <u>3-6</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3-6</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J R Dwyer</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dwyer</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>Mar. 12 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1957	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

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MAR 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03426

CERTIFICATE OF DEATH

03395

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown 10X12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Ralph</u> Last <u>Kepler</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/1896</u>
9. AGE (In years last birthday) yrs. <u>60</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Kepler</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Derr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-34-6496</u>	
17. INFORMANT <u>Mrs. Charles Leatherman, Middletown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalize arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pyonephrosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>March 19, 1957</u> , that I last saw the deceased alive on <u>March 18, 1957</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.		ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>3/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Gerald W. LeVan</u>		<u>Boonsboro, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/21/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Mar. 22, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>John S. Paul</u>	

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03396

03387

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Maryland</u> COUNTY <u>Washington</u>		CITY <u>Hagerstown</u>		CITY <u>Hagerstown</u>	
CITY <u>Hagerstown</u>		LENGTH OF STAY <u>2 weeks</u>		TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS <u>937 Concord Street</u>					
3. NAME OF DECEASED (Type or Print) <u>Gilbert R. Kerns</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 6, 1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James H. Kerns</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Hartley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Laura Bell Kerns Hagerstown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Generalized Atherosclerosis</u>				<u>5 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Pulmonary Embolism</u>				<u>2 days.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 26, 1957</u> , to <u>March 18, 1957</u> , that I last saw the deceased alive on <u>March 17, 1957</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. H. Bowers</u>				ADDRESS (Street, city, town, state) <u>1500 W. Washington St. Hagerstown Md.</u> DATE SIGNED <u>3/19/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>March 21, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Lee & Son Crematory</u>		LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
24. REC'D BY REGISTRAR <u>Mar. 23, 1957</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Howe</u> ADDRESS <u>Hancock Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03397
03388 Item 9 FilmG213 4-11-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN b 13 years		d. STREET ADDRESS 751 S. Potomac St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Ervin Lewis		4. DATE OF DEATH March 18 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1880
9. AGE (In years last birthday) 75 7/6 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Foxville Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alfred Lewis		14. MOTHER'S MAIDEN NAME Rebecca Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-0827	
17. INFORMANT Mrs. Carrie V. Lewis		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema & pneumonia 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) grip & arteriosclerosis DUE TO (c) grip & arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sew weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/27/57 , 19____, to 3/18/57 , 19____, that I lost saw the deceased olive on 3/18/57 , 19____, and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac Street DATE SIGNED 3/19/57			
ACTUAL SIGNATURE Howard N. Weeks M.D.		136 North Potomac Street	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Mar. 21. 1957		24b. REGISTRAR'S SIGNATURE Howard N. Weeks	

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Richard Mann

1-14-082/MIN. CATTIN V. LEWIS

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BUREAU V. S.

MAR 26 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04555

03389

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>6 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA BELLE LINE</u>				4. DATE OF DEATH Month Day Year <u>MARCH - 31 - 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY - 14 - 1872</u>	
9. AGE (In years lost birthday) <u>84-8-17</u> rs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>THOMAS LINE</u>				14. MOTHER'S MAIDEN NAME <u>MALINDA TOMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>FRANK LINE 616 W. FRANKLIN ST. HAGERSTOWN MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of both ovaries.</u> 175X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Feb 4</u> , 1957, to <u>March 31</u> , 1957, that I last saw the deceased alive on <u>March 30</u> , 1957, and that death occurred at <u>Neen M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>4/2/57</u>			
PHYSICIAN'S NAME (Type) <u>G.W. LeVan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL - 4 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>Apr. 6, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

APR 9 1957

RECEIVED

03390

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 24 Hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 623 George St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMMA GRACE LORSHBAUGH				4. DATE OF DEATH Month Day Year Mar 19 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 12 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Knitter		10b. KIND OF BUSINESS OR INDUSTRY Hosiery Mills	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Kriner			
14. MOTHER'S MAIDEN NAME Florence Sell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-09-8179	
17. INFORMANT Mrs Margaret Barrow				Address 623 George St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral and Aortic Stenosis, severe, Pulmonary Emphysema. 410X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown Md.				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from 3/15 , 19 57 , to 3/19 , 19 57 , that I last saw the deceased alive on 3/19 , 19 57 , and that death occurred at 220 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George Jennings				ADDRESS (Street, city or town, state) 136 W. Washington St. Hagerstown, Md.			
DATE SIGNED 3/20/57				PHYSICIAN'S NAME (Type) George Jennings			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mar 23 1957	
				24b. REGISTRAR'S SIGNATURE Chas. H. Sowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 3

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03391

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Court House				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Hagerstown R # 2 d. STREET ADDRESS --- e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE WILSON LOUDENSLAGER First Middle Last Sr				4. DATE OF DEATH Month Day Year March 21 1957 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feby 19 1901 56	
9. AGE (In years last birthday) yrs. 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Loudenslager				14. MOTHER'S MAIDEN NAME Emma Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 241-09-4055		17. INFORMANT Address R # 2 Md Virginia F. Loudenslager Hagerstown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) 7/21/57 DUE TO (c) 12/3/56						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-3- , 1956 , to 3-21- , 1957 , that I last saw the deceased alive on 3-14-57 , 19, and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sr Dr Ditto				ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 3/23/57			
PHYSICIAN'S NAME (Type) Sr Dr Ditto				M.D. Hagerstown Md 3/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mar. 25/57	
				24b. REGISTRAR'S SIGNATURE Blair H. Bowers			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. No. 10

BUREAU V. S.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03400

03392

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithburg 10x22</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Luella Irene Lovell</u>				4. DATE OF DEATH Month Day Year <u>March 10, 1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/11/1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Josiah Smith</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>J. Floyd Lovell, Smithburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>2 dy.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. si. p. m. _____ Month, Day, Year _____ <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 9</u> , 19 <u>57</u> , to <u>Mar. 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar. 10</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>R. S. Stauffer</u> M.D. <u>170 W. Washington St</u> PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u> <u>Hagerstown Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garfield E. U. B. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR <u>Mar 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Woodward</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		YEAR	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
DISEASE		SYMPTOMS		TREATMENT		DIAGNOSIS		HISTORICAL	
FAMILY HISTORY		PREVIOUS ILLNESS		HABITS		SOCIAL HISTORY		MENTAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS		OTHER EXAMINATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03401

03393

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1 139 Randolph Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillie May Lum				4. DATE OF DEATH Month Day Year March 22 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1900		9. AGE (In years lost birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Steelton, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William C. Fish				14. MOTHER'S MAIDEN NAME Ida C. Turpin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-28-8091		17. INFORMANT Address Mrs. Clara Bonney, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus 174X DUE TO Metastasis to liver (jaundice & ascites) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs lyr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour o. ft. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Oct. 19 46 to March 22, 1957 , that I last saw the deceased alive on March 22 1957 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-23-57 DATE SIGNED							
ACTUAL SIGNATURE S. Robert Wells		M.D. 3-23-57					
PHYSICIAN'S NAME (Type) Samuel Wells, M.D.		115 N. Potomac St., Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-26-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24. REC'D BY REGISTRAR Mar 26, 1957		24b. REGISTRAR'S SIGNATURE Chas H. Bowser	

08394

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Roy Magaha				4. DATE OF DEATH Month March Day 20 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY refrigeration		11. BIRTHPLACE (State or foreign country) Sheperdstown, W.Va.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Henry Magaha				14. MOTHER'S MAIDEN NAME Jennie Swain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-5883		17. INFORMANT Address Mrs. Glenn Magaha, Hagerstown Rd 5, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept 27, 19 54 to March 20, 19 57 , that I last saw the deceased alive on March 20, 1957 , and that death occurred at 1235 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Boyer, M.D.				ADDRESS (Street, city or town, state) 135 N. Potomac St., Hagerstown, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED 3/22/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-23-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or County) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 25, 1957		24b. REGISTRAR'S SIGNATURE Charles Bowers	

[illegible]

BUREAU V. S.

MAR 27 1957

RECEIVED

03395

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 309 Radcliffe Avenue</u>				d. STREET ADDRESS <u>309 Radcliffe Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Edgar</u> Last <u>McCarren</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>31</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete Hauling</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles McCarren</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Eckenrode</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. C. E. McCarren, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 24</u> , 19 <u>57</u> , to <u>Mar. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar. 30</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis G. Graft</u>				ADDRESS (Street, city or town, state) <u>119 S. Antietam St. Hagerstown, MD.</u>			
PHYSICIAN'S NAME (Type) <u>Louis G. Graft</u>				DATE SIGNED <u>4-1-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ringer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowser</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		Male		39		12/1/27		MOBILE, ALABAMA		None		Single		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS	
4/4/68		10:00 AM		FBI, WASHINGTON, D.C.		Suicide		Homicide		[Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. FILING OFFICE		22. FILING DATE		23. FILING TIME		24. FILING OFFICIAL	
District of Columbia		Washington		DC		20540		FBI		4/4/68		10:00 AM		[Signature]	

BUREAU V. 3

APR 8 1968

RECEIVED

03396

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1802 Virginia Avenue</u>				d. STREET ADDRESS <u>1802 Virginia Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Edward McClain</u>				4. DATE OF DEATH Month Day Year <u>Mar. 21 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1897</u>		9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days <u>7 1</u>	IF UNDER 24 HRS. Hours Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Money Order Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel S. McClain</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Lushbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Lawrence McClain, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Rt Kidney - Recurrent</u> <u>180x</u> DUE TO <u>metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260x</u> (b) <u>Diabetes Mellitus</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 16</u> , 19 <u>50</u> , to <u>March 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>57</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Phyllis Shelman</u>				ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown Md 21740</u>			
PHYSICIAN'S NAME (Type) <u>R. Franklin Boyer</u>				DATE SIGNED <u>Mar. 22, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				24a. REC'D BY REGISTRAR <u>Mar. 22, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Shelman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111

Source: *U.S. Census Bureau, 1997*

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7. E-12-C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G212 3-18-57 et

03405

CERTIFICATE OF DEATH

Reg. Dist. No.

303

03397

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3½ years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle M Last McKee		4. DATE OF DEATH Month 3 Day 8 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1863/ 1862
9. AGE (In years lost by day) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY school teacher	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Axline		14. MOTHER'S MAIDEN NAME Elizabeth Younker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Grover McHenry		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis - Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis - 30 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 yrs 7 yrs ±
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1942 to Mar. 8, 1957 , that I last saw the deceased alive on March 8, 1957 , and that death occurred at 12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 3/9/57			
ACTUAL SIGNATURE Lloyd A. Hoffman M.D. 3/9/57			
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-11-57	
22c. NAME OF CEMETERY OR CREMATORY Lutheran		22d. LOCATION (City, town, or county) (State) Lovettsville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Mar. 12, 1957		24b. REGISTRAR'S SIGNATURE Wesley Bowers	

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.	
REPORT OF SPECIAL AGENT IN CHARGE		DATE: 10-10-57	
TO: SAC, NEW YORK		FROM: SAC, NEW YORK	
SUBJECT: [REDACTED]		RE: [REDACTED]	
1. [REDACTED]		2. [REDACTED]	
3. [REDACTED]		4. [REDACTED]	
5. [REDACTED]		6. [REDACTED]	
7. [REDACTED]		8. [REDACTED]	
9. [REDACTED]		10. [REDACTED]	
11. [REDACTED]		12. [REDACTED]	
13. [REDACTED]		14. [REDACTED]	
15. [REDACTED]		16. [REDACTED]	
17. [REDACTED]		18. [REDACTED]	
19. [REDACTED]		20. [REDACTED]	
21. [REDACTED]		22. [REDACTED]	
23. [REDACTED]		24. [REDACTED]	
25. [REDACTED]		26. [REDACTED]	
27. [REDACTED]		28. [REDACTED]	
29. [REDACTED]		30. [REDACTED]	
31. [REDACTED]		32. [REDACTED]	
33. [REDACTED]		34. [REDACTED]	
35. [REDACTED]		36. [REDACTED]	
37. [REDACTED]		38. [REDACTED]	
39. [REDACTED]		40. [REDACTED]	
41. [REDACTED]		42. [REDACTED]	
43. [REDACTED]		44. [REDACTED]	
45. [REDACTED]		46. [REDACTED]	
47. [REDACTED]		48. [REDACTED]	
49. [REDACTED]		50. [REDACTED]	
51. [REDACTED]		52. [REDACTED]	
53. [REDACTED]		54. [REDACTED]	
55. [REDACTED]		56. [REDACTED]	
57. [REDACTED]		58. [REDACTED]	
59. [REDACTED]		60. [REDACTED]	
61. [REDACTED]		62. [REDACTED]	
63. [REDACTED]		64. [REDACTED]	
65. [REDACTED]		66. [REDACTED]	
67. [REDACTED]		68. [REDACTED]	
69. [REDACTED]		70. [REDACTED]	
71. [REDACTED]		72. [REDACTED]	
73. [REDACTED]		74. [REDACTED]	
75. [REDACTED]		76. [REDACTED]	
77. [REDACTED]		78. [REDACTED]	
79. [REDACTED]		80. [REDACTED]	
81. [REDACTED]		82. [REDACTED]	
83. [REDACTED]		84. [REDACTED]	
85. [REDACTED]		86. [REDACTED]	
87. [REDACTED]		88. [REDACTED]	
89. [REDACTED]		90. [REDACTED]	
91. [REDACTED]		92. [REDACTED]	
93. [REDACTED]		94. [REDACTED]	
95. [REDACTED]		96. [REDACTED]	
97. [REDACTED]		98. [REDACTED]	
99. [REDACTED]		100. [REDACTED]	
101. [REDACTED]		102. [REDACTED]	
103. [REDACTED]		104. [REDACTED]	
105. [REDACTED]		106. [REDACTED]	
107. [REDACTED]		108. [REDACTED]	
109. [REDACTED]		110. [REDACTED]	
111. [REDACTED]		112. [REDACTED]	
113. [REDACTED]		114. [REDACTED]	
115. [REDACTED]		116. [REDACTED]	
117. [REDACTED]		118. [REDACTED]	
119. [REDACTED]		120. [REDACTED]	
121. [REDACTED]		122. [REDACTED]	
123. [REDACTED]		124. [REDACTED]	
125. [REDACTED]		126. [REDACTED]	
127. [REDACTED]		128. [REDACTED]	
129. [REDACTED]		130. [REDACTED]	
131. [REDACTED]		132. [REDACTED]	
133. [REDACTED]		134. [REDACTED]	
135. [REDACTED]		136. [REDACTED]	
137. [REDACTED]		138. [REDACTED]	
139. [REDACTED]		140. [REDACTED]	
141. [REDACTED]		142. [REDACTED]	
143. [REDACTED]		144. [REDACTED]	
145. [REDACTED]		146. [REDACTED]	
147. [REDACTED]		148. [REDACTED]	
149. [REDACTED]		150. [REDACTED]	
151. [REDACTED]		152. [REDACTED]	
153. [REDACTED]		154. [REDACTED]	
155. [REDACTED]		156. [REDACTED]	
157. [REDACTED]		158. [REDACTED]	
159. [REDACTED]		160. [REDACTED]	
161. [REDACTED]		162. [REDACTED]	
163. [REDACTED]		164. [REDACTED]	
165. [REDACTED]		166. [REDACTED]	
167. [REDACTED]		168. [REDACTED]	
169. [REDACTED]		170. [REDACTED]	
171. [REDACTED]		172. [REDACTED]	
173. [REDACTED]		174. [REDACTED]	
175. [REDACTED]		176. [REDACTED]	
177. [REDACTED]		178. [REDACTED]	
179. [REDACTED]		180. [REDACTED]	
181. [REDACTED]		182. [REDACTED]	
183. [REDACTED]		184. [REDACTED]	
185. [REDACTED]		186. [REDACTED]	
187. [REDACTED]		188. [REDACTED]	
189. [REDACTED]		190. [REDACTED]	
191. [REDACTED]		192. [REDACTED]	
193. [REDACTED]		194. [REDACTED]	
195. [REDACTED]		196. [REDACTED]	
197. [REDACTED]		198. [REDACTED]	
199. [REDACTED]		200. [REDACTED]	
201. [REDACTED]		202. [REDACTED]	
203. [REDACTED]		204. [REDACTED]	
205. [REDACTED]		206. [REDACTED]	
207. [REDACTED]		208. [REDACTED]	
209. [REDACTED]		210. [REDACTED]	
211. [REDACTED]		212. [REDACTED]</	

BUREAU A

MAR 14 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03398

CERTIFICATE OF DEATH

03406

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>0.3 Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>249 North Mulberry St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> <u>Franklin</u> <u>Miles</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Maintenance Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Company</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Daniel Miles</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Catherine Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-16-0130</u>		17. INFORMANT <u>Mary V. Miles, Hagerstown, Maryland</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Prostate Hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>7 days</u> <u>4 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>56</u> , to <u>March 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>57</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. G. Warden</u> M.D.				ADDRESS (Street, city or town, state) <u>832 Potomac Ave., Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. G. Warden, M.D.</u>				DATE SIGNED <u>March 5, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Paul, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouser</u>				ADDRESS <u>Suter-Rouser Funeral Home Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>March 5, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03399

CERTIFICATE OF DEATH

03407
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>70 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>910 Potomac Avenue</u>				d. STREET ADDRESS <u>910 Potomac Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Franklin</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1864</u>	9. AGE (In years last birthday) <u>92 yrs.</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Goods Buyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Eyerly's Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Maryland</u>	
13. FATHER'S NAME <u>Michael Miller</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. John McKee, Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 19, 1957</u> , to <u>March 19, 1957</u> , that I last saw the deceased alive on <u>March 18, 1957</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington Street 3/19/57</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sister-Rosey Funeral Home</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Mar. 22, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blanch Bowers</u>			

CERTIFICATE OF DEATH

1. USUAL RESIDENCE OF DECEASED		2. PLACE OF DEATH	
3. DATE OF DEATH		4. TIME OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. MANNER OF DEATH		8. AGENT OF DEATH	
9. SEX		10. AGE	
11. RACE		12. COLOR	
13. BIRTH DATE		14. BIRTH PLACE	
15. MARRIAGE DATE		16. MARRIAGE PLACE	
17. PREVIOUS MARRIAGES		18. PREVIOUS DEATHS	
19. PREVIOUS DEATHS		20. PREVIOUS DEATHS	
21. PREVIOUS DEATHS		22. PREVIOUS DEATHS	
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89. PREVIOUS DEATHS		90. PREVIOUS DEATHS	
91. PREVIOUS DEATHS		92. PREVIOUS DEATHS	
93. PREVIOUS DEATHS		94. PREVIOUS DEATHS	
95. PREVIOUS DEATHS		96. PREVIOUS DEATHS	
97. PREVIOUS DEATHS		98. PREVIOUS DEATHS	
99. PREVIOUS DEATHS		100. PREVIOUS DEATHS	

BUREAU V. S.

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03408

302

03400

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1924 Virginia Ave.</u>		e. STREET ADDRESS <u>1924 Virginia Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Florence Moats</u>		4. DATE OF DEATH Month Day Year <u>March 17 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook Restaurant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
13. FATHER'S NAME <u>Hamilton Miller</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-1010</u>	
17. INFORMANT <u>Mr. Harry T. Moats</u>		18. ADDRESS <u>1924 Virginia Ave. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16/57</u> 19 <u>57</u> , to <u>3/17/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>3/17/57</u> 19 <u>57</u> , and that death occurred at <u>6</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.		ADDRESS (Street, city or town, state) <u>Wilkesboro, Md.</u> DATE SIGNED <u>3/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Ralph F. Young M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Leaf Williamsport, Md.</u>		24. REC'D BY REGISTRAR <u>Mar. 19, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>			

BUREAU V. S.

MAR 20 1957

RECEIVED

CERTIFICATE OF DEATH

03409

Reg. Dist. No.

302

03401

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Washington</u> Last <u>Moulden</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1896</u>		9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Room Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. News Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Brucetown, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Alben</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-09-8071</u>		17. INFORMANT <u>Mrs. Carl Moulden, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac dilatation & failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), (c) <u>Coronary sclerosis</u> DUE TO <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrothorax, Pericarditis, Congested liver</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 July, 1956</u> , to <u>21 Mar, 1957</u> , that I last saw the deceased alive on <u>21 Mar '57</u> , 19 <u>57</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1135 POTOMAC AVENUE, HAGERSTOWN, MD.</u> DATE SIGNED <u>23 MARCH 1957</u>							
ACTUAL SIGNATURE <u>Richard T. Binford</u>		M.D. <u>1135 POTOMAC AVENUE, HAGERSTOWN, MD.</u>					
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Pomeroy Funeral Home</u> <u>R. Franklin Pomeroy</u>		ADDRESS <u>305 North Potomac Street</u>		24a. REC'D BY REGISTRAR <u>Mar 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Walter H. Bowers</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 03410
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
3. NAME OF DECEASED (Type or print) First J Middle Henry Last Myers		4. DATE OF DEATH Month 3 Day 20 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1874
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	11. BIRTHPLACE (State or foreign country) Wash. Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Emanuel Myers	
14. MOTHER'S MAIDEN NAME Sarah Shaw		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 166-09-2056-1		17. INFORMANT Mr. A. A. Weaver Address Williamsport, Md. R2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic carcinoma of bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 9 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-2 , 19 56 , to 3-20-57 , 19 57 , that I last saw the deceased alive on 3-20-57 , 19 57 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 King St., Hagerstown, Md. DATE SIGNED 3-20-57			
ACTUAL SIGNATURE Joseph C. Crisp		M.D. 115 King St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Joseph C. Crisp, M.D.		115 King St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 22, 1957	24b. REGISTRAR'S SIGNATURE Chas. H. Bower

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

03427

CERTIFICATE OF DEATH

03411

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.				c. LENGTH OF STAY IN 1b 69 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 W. Salisbury Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Spickler Newcomer				4. DATE OF DEATH Month Day Year March 17 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5 1887	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 11 Days 11		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME John J. Spickler				14. MOTHER'S MAIDEN NAME Kate Bragunier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Grayson Newcomer		Address 13 W. Salisbury St Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 420.1							INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16/57 to 3/17/57, that I last saw the deceased alive on 3/17/57, 19, and that death occurred at 3 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Ralph F. Young M. D. Williamsport Md 3/17/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF March 19-57		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
22d. LOCATION (City, town, or county) Williamsport Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Address Albert R. Leaf Williamsport, Md				24a. REC'D BY REGISTRAR March 19-57		24b. REGISTRAR'S SIGNATURE Lee M. Elroy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 2

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03412

03403

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>X1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VADA</u> Middle <u>NAOMI</u> Last <u>PALMER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8-1890</u>	9. AGE (In years last birthday) <u>66-9-18</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MIDDLETOWN FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES R. LEMON</u>				14. MOTHER'S MAIDEN NAME <u>MARY CLINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>RAY M. PALMER</u> Address <u>BOONSBORO MD. R.2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronch. pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>auricular Fibrillation</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 18, 1957</u> to <u>March 26, 1957</u> , that I last saw the deceased alive on <u>March 26, 1957</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Hedman</u> M.D.				ADDRESS (Street/city or town, state) <u>Boonsboro</u> DATE SIGNED <u>3/28/57</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Hedman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 29, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	
				24a. REC'D BY REGISTRAR <u>APR 2, 1957</u>			

BUREAU V. S.

APR 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

03404

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03413
302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 22 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 17 PUBLIC SQUARE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle BARNETT Last POTTER				4. DATE OF DEATH Month MARCH Day 20 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25/1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10b. KIND OF BUSINESS OR INDUSTRY OWN SHOP		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BARNETT				14. MOTHER'S MAIDEN NAME MARY HUSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-2103		17. INFORMANT MR. JOHN E. POTTER SR.		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 3-22-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/23/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 25, 1957		24b. REGISTRAR'S SIGNATURE Phasht K. Powers	

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		St. Louis, Missouri	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
St. Louis, Missouri		Attorney		High School		Married		Suicide		Suicide	
FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		TREATMENT		HISTORY	
James Earl Ray, Sr.		Berneice Ray		None		None		None		None	
BORN		DIED		BORN		DIED		BORN		DIED	
April 24, 1933		April 4, 1968		April 24, 1933		April 4, 1968		April 24, 1933		April 4, 1968	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri		St. Louis, Missouri	
FATHER'S NAME		MOTHER'S NAME		FATHER'S NAME		MOTHER'S NAME		FATHER'S NAME		MOTHER'S NAME	
James Earl Ray, Sr.		Berneice Ray		James Earl Ray, Sr.		Berneice Ray		James Earl Ray, Sr.		Berneice Ray	
BORN		DIED		BORN		DIED		BORN		DIED	
April 24, 1933		April 4, 1968		April 24, 1933		April 4, 1968		April 24, 1933		April 4, 1968	

RECEIVED
 MAR 27 1968
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03405

CERTIFICATE OF DEATH

03414

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
3. NAME OF DECEASED (Type or print) First <u>MARSHALL</u> Middle <u>LIEWELLYN</u> Last <u>RICHARDSON</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Metal Working Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Clearfield, Pa.</u>	
13. FATHER'S NAME <u>William M. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-0192</u>		17. INFORMANT Address <u>Mrs. William Hoffman Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X pulmonary congestion</u> DUE TO (b) <u>Bronchial asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/27/57</u> , 19 <u> </u> , to <u>3/20/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>3/20/57</u> , 19 <u> </u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 North Potomac St. Hagerstown, Maryland</u> DATE SIGNED <u>3/22/57</u>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar. 22, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>			

BUREAU V. S.

MAR 26 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03415

03406

CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>11021 Woodland Way</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN N. Rohrbach</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1898</u>	
9. AGE (In years lost birthday) <u>58 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Power Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alwen Rohrbach</u>		14. MOTHER'S MAIDEN NAME <u>Alice Meckel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-3342</u>		17. INFORMANT <u>Mr. Jesse B. Humphrey - Hagerstown - Md.</u>		Address <u>Braddock</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hour</u> <u>4-5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Frederick - Md.</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>45</u> , to <u>Mar 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 25</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. Campbell</u> M.D. <u>Hagerstown Md</u>				DATE SIGNED <u>3/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. Campbell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>Frederick - Md.</u>				24a. REC'D BY REGISTRAR DATE <u>29 March 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Lowery</u>	

BUREAU V. S.

APR 1 1957

RECEIVED

03407

CERTIFICATE OF DEATH

Dr Jennings

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Hagerstown R #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>Western Pike</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY TERESA ROYCE</u>		4. DATE OF DEATH Month Day Year <u>March 31 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31 1957</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md Hagerstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph F. Royce</u>		14. MOTHER'S MAIDEN NAME <u>Donna Baumann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ralph F. Royce Hagerstown Md R # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 6 months pregnancy</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/31</u> , 19 <u>57</u> , to <u>3/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/31/57</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>4/1/57</u>			
ACTUAL SIGNATURE <u>George Jennings</u> M.D.		PHYSICIAN'S NAME (Type) <u>George Jennings</u> <u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081141XV00

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		MD		MD		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1905		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
SCHOOL		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
BUSINESS		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
RELIGION		METHODIST		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
METHODIST		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
CAUSE OF DEATH		HEART DISEASE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
DATE OF DEATH		APR 3 1957		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
APR 3 1957		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
PLACE OF DEATH		HOME		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HOME		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA		BALTIMORE	

BUREAU V. S.

APR 4 1957

RECEIVED

Andrew K. Gottlieb, Registrar

03408

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 45 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle RUSSELL Last SANBOWER				4. DATE OF DEATH Month MARCH Day 5 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/1894	
9. AGE (In years lost birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIQUOR DEALER		10b. KIND OF BUSINESS OR INDUSTRY WHOLESALE RETAIL STORE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GEORGE W. SANBOWER			
14. MOTHER'S MAIDEN NAME LILLIE JONES				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT MRS. EVA S. SANBOWER Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total renal shutdown, uremia, peripheral vascular 4460X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nodular hyperplasia of prostate INTERVAL BETWEEN ONSET AND DEATH 1 day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 9 , 19 56 , to March 5 , 19 57 , that I last saw the deceased alive on Mar. 5 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Joseph C. Crisp M.D. PHYSICIAN'S NAME (Type) Joseph C. Crisp, M. D. 115 King St., Hagerstown, Md.							
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 3/7/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 8, 1957		24b. REGISTRAR'S SIGNATURE Thas Rovers	

RECEIVED

03409

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 E. Franklin St.		d. STREET ADDRESS 130 E. Franklin St.	
3. NAME OF DECEASED (Type or print) Clifford First Newton Middle Schildknecht Last		4. DATE OF DEATH March Month 2 Day 1957 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1886
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brick Layer Construction Church Hill Fred Co. Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David W. Schildknecht		14. MOTHER'S MAIDEN NAME Cordelia C. Paliver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Lottie Schildknecht Hagerstown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) auricular fibrillation, myocardial failure 480.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mos + 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 26 Feb , 19 57 , to 2 Mar , 19 57 , that I last saw the deceased alive on 1 Mar , 19 57 , and that death occurred at 3:00 A M., from the causes and on the date stated above.			
ACTUAL SIGNATURE F F Lusby		ADDRESS (Street, city or town, state) 230 N Potomac	
PHYSICIAN'S NAME (Type) F F Lusby		DATE SIGNED 4 Mar 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-4-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.		24. REC'D BY REGISTRAR Mar 5 1957	24b. REGISTRAR'S SIGNATURE Frank Bowers

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03410

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 639 West Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle L Last SCHUSTER		4. DATE OF DEATH Month March Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 14 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Schuster		14. MOTHER'S MAIDEN NAME Barbara Weymer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Ethel C. Mowen		Address 402 W. Washington St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic heart disease with 420.0 DUE TO myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 195 6 , to 14 Mar , 195 7 , that I last saw the deceased alive on 13 Mar , 195 7 , and that death occurred at 1:45 P . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F F Lusby		ADDRESS (Street, city or town, state) 230 W Patoma DATE SIGNED 15 Mar 57	
PHYSICIAN'S NAME (Type) F F Lusby		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Goffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Mar 18 1957		24b. REGISTRAR'S SIGNATURE Chas H Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

DATE OF DEATH: _____
PLACE OF DEATH: _____

DECEASED'S NAME: _____
AGE: _____

SEX: _____
RACE: _____

DATE OF BIRTH: _____
PLACE OF BIRTH: _____

EDUCATION: _____
OCCUPATION: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____

DATE OF EXAMINATION: _____
PLACE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF CORONER: _____

DATE OF INTERMENT: _____
PLACE OF INTERMENT: _____

DATE OF BURIAL: _____
PLACE OF BURIAL: _____

DATE OF CREMATION: _____
PLACE OF CREMATION: _____

DATE OF EXHUMATION: _____
PLACE OF EXHUMATION: _____

DATE OF REINTERMENT: _____
PLACE OF REINTERMENT: _____

DATE OF RECREMATION: _____
PLACE OF RECREMATION: _____

DATE OF REEXHUMATION: _____
PLACE OF REEXHUMATION: _____

DATE OF REINTERMENT: _____
PLACE OF REINTERMENT: _____

DATE OF RECREMATION: _____
PLACE OF RECREMATION: _____

DATE OF REEXHUMATION: _____
PLACE OF REEXHUMATION: _____

BUREAU V. S.

MAR 20 1957

RECEIVED

03411

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 Broadway</u>				d. STREET ADDRESS <u>1 21 Broadway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ROLLIN</u> Middle <u>PAUL</u> Last <u>SHATTO</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Sharon Mercer Co Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clyde O. Shatto</u>				14. MOTHER'S MAIDEN NAME <u>Maude Powers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-7297</u>		17. INFORMANT <u>Elizabeth Shatto</u> Address <u>21 Broadway Hagerstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Acute coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>15 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour 15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-16, 1942</u> to <u>3-25, 1957</u> , that I last saw the deceased alive on <u>3-25, 1957</u> , and that death occurred at <u>7:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Maryland</u>			
DATE SIGNED <u>3:25:57</u>							
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>Mar 29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth Shatto</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03412
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03421
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Martin Shives</u>		4. DATE OF DEATH Month Day Year <u>March 17 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>9 8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Shives</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Sweeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lloyd Shives</u>		Address <u>Hancock, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriolar nephrosclerosis with Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>indeterminate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Papillary adenocarcinoma bladder</u> <u>indeterminate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5, 1957</u> , to <u>March 17, 1957</u> , that I last saw the deceased alive on <u>March 17, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 100 Professional Arts Bldg. 3-19-57</u>			
ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>		PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Stone Hancock Md</u>		24a. REC'D BY REGISTRAR <u>March 23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Powers</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERGYMAN		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. S.

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

03422

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>	
c. LENGTH OF STAY IN b. <u>4 Hours</u>		d. STREET ADDRESS <u>Route 6 - Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA SUSAN SHUCK</u>		4. DATE OF DEATH Month Day Year <u>March 7 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David H. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eshleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry M. Shuck</u> Address <u>State Line, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease, Arteriosclerotic</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced grade involutional psychosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1945</u> , to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 7, 1957</u> , at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D. <u>Greencastle, Pa.</u>		DATE SIGNED <u>5/8/57</u>	
PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>Mar. 9, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W.C. Brewer</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>March 10, 1957</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Engineer</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>		10. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
11. SIGNATURE OF DECEASED <i>John J. Smith</i>		12. SIGNATURE OF NEXT OF KIN <i>John J. Smith</i>		13. SIGNATURE OF WITNESS <i>John J. Smith</i>		14. SIGNATURE OF WITNESS <i>John J. Smith</i>		15. SIGNATURE OF WITNESS <i>John J. Smith</i>	
16. SIGNATURE OF WITNESS <i>John J. Smith</i>		17. SIGNATURE OF WITNESS <i>John J. Smith</i>		18. SIGNATURE OF WITNESS <i>John J. Smith</i>		19. SIGNATURE OF WITNESS <i>John J. Smith</i>		20. SIGNATURE OF WITNESS <i>John J. Smith</i>	
21. SIGNATURE OF WITNESS <i>John J. Smith</i>		22. SIGNATURE OF WITNESS <i>John J. Smith</i>		23. SIGNATURE OF WITNESS <i>John J. Smith</i>		24. SIGNATURE OF WITNESS <i>John J. Smith</i>		25. SIGNATURE OF WITNESS <i>John J. Smith</i>	
26. SIGNATURE OF WITNESS <i>John J. Smith</i>		27. SIGNATURE OF WITNESS <i>John J. Smith</i>		28. SIGNATURE OF WITNESS <i>John J. Smith</i>		29. SIGNATURE OF WITNESS <i>John J. Smith</i>		30. SIGNATURE OF WITNESS <i>John J. Smith</i>	
31. SIGNATURE OF WITNESS <i>John J. Smith</i>		32. SIGNATURE OF WITNESS <i>John J. Smith</i>		33. SIGNATURE OF WITNESS <i>John J. Smith</i>		34. SIGNATURE OF WITNESS <i>John J. Smith</i>		35. SIGNATURE OF WITNESS <i>John J. Smith</i>	
36. SIGNATURE OF WITNESS <i>John J. Smith</i>		37. SIGNATURE OF WITNESS <i>John J. Smith</i>		38. SIGNATURE OF WITNESS <i>John J. Smith</i>		39. SIGNATURE OF WITNESS <i>John J. Smith</i>		40. SIGNATURE OF WITNESS <i>John J. Smith</i>	
41. SIGNATURE OF WITNESS <i>John J. Smith</i>		42. SIGNATURE OF WITNESS <i>John J. Smith</i>		43. SIGNATURE OF WITNESS <i>John J. Smith</i>		44. SIGNATURE OF WITNESS <i>John J. Smith</i>		45. SIGNATURE OF WITNESS <i>John J. Smith</i>	
46. SIGNATURE OF WITNESS <i>John J. Smith</i>		47. SIGNATURE OF WITNESS <i>John J. Smith</i>		48. SIGNATURE OF WITNESS <i>John J. Smith</i>		49. SIGNATURE OF WITNESS <i>John J. Smith</i>		50. SIGNATURE OF WITNESS <i>John J. Smith</i>	
51. SIGNATURE OF WITNESS <i>John J. Smith</i>		52. SIGNATURE OF WITNESS <i>John J. Smith</i>		53. SIGNATURE OF WITNESS <i>John J. Smith</i>		54. SIGNATURE OF WITNESS <i>John J. Smith</i>		55. SIGNATURE OF WITNESS <i>John J. Smith</i>	
56. SIGNATURE OF WITNESS <i>John J. Smith</i>		57. SIGNATURE OF WITNESS <i>John J. Smith</i>		58. SIGNATURE OF WITNESS <i>John J. Smith</i>		59. SIGNATURE OF WITNESS <i>John J. Smith</i>		60. SIGNATURE OF WITNESS <i>John J. Smith</i>	
61. SIGNATURE OF WITNESS <i>John J. Smith</i>		62. SIGNATURE OF WITNESS <i>John J. Smith</i>		63. SIGNATURE OF WITNESS <i>John J. Smith</i>		64. SIGNATURE OF WITNESS <i>John J. Smith</i>		65. SIGNATURE OF WITNESS <i>John J. Smith</i>	
66. SIGNATURE OF WITNESS <i>John J. Smith</i>		67. SIGNATURE OF WITNESS <i>John J. Smith</i>		68. SIGNATURE OF WITNESS <i>John J. Smith</i>		69. SIGNATURE OF WITNESS <i>John J. Smith</i>		70. SIGNATURE OF WITNESS <i>John J. Smith</i>	
71. SIGNATURE OF WITNESS <i>John J. Smith</i>		72. SIGNATURE OF WITNESS <i>John J. Smith</i>		73. SIGNATURE OF WITNESS <i>John J. Smith</i>		74. SIGNATURE OF WITNESS <i>John J. Smith</i>		75. SIGNATURE OF WITNESS <i>John J. Smith</i>	
76. SIGNATURE OF WITNESS <i>John J. Smith</i>		77. SIGNATURE OF WITNESS <i>John J. Smith</i>		78. SIGNATURE OF WITNESS <i>John J. Smith</i>		79. SIGNATURE OF WITNESS <i>John J. Smith</i>		80. SIGNATURE OF WITNESS <i>John J. Smith</i>	
81. SIGNATURE OF WITNESS <i>John J. Smith</i>		82. SIGNATURE OF WITNESS <i>John J. Smith</i>		83. SIGNATURE OF WITNESS <i>John J. Smith</i>		84. SIGNATURE OF WITNESS <i>John J. Smith</i>		85. SIGNATURE OF WITNESS <i>John J. Smith</i>	
86. SIGNATURE OF WITNESS <i>John J. Smith</i>		87. SIGNATURE OF WITNESS <i>John J. Smith</i>		88. SIGNATURE OF WITNESS <i>John J. Smith</i>		89. SIGNATURE OF WITNESS <i>John J. Smith</i>		90. SIGNATURE OF WITNESS <i>John J. Smith</i>	
91. SIGNATURE OF WITNESS <i>John J. Smith</i>		92. SIGNATURE OF WITNESS <i>John J. Smith</i>		93. SIGNATURE OF WITNESS <i>John J. Smith</i>		94. SIGNATURE OF WITNESS <i>John J. Smith</i>		95. SIGNATURE OF WITNESS <i>John J. Smith</i>	
96. SIGNATURE OF WITNESS <i>John J. Smith</i>		97. SIGNATURE OF WITNESS <i>John J. Smith</i>		98. SIGNATURE OF WITNESS <i>John J. Smith</i>		99. SIGNATURE OF WITNESS <i>John J. Smith</i>		100. SIGNATURE OF WITNESS <i>John J. Smith</i>	

BUREAU V. J.

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03414

CERTIFICATE OF DEATH

03423

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 131 West Church Street		e. STREET ADDRESS 131 West Church Street	
3. NAME OF DECEASED (Type or print) Mattie First Middle (ne) Last Smith		4. DATE OF DEATH Month March Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24 1868
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Braxton		14. MOTHER'S MAIDEN NAME Mattie Lyles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Jane Semerville		Address 131 W. Church St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease 432.1 DUE TO with myocardial failure grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I attended the deceased from Feb. 19 57 , to March 1 , 19 57 , that I last saw the deceased alive on Feb. 26 , 19 57 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Robert Wells		ADDRESS (Street, city or town, state) DATE SIGNED 115 N. Potomac Street 3-4-57	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson		ADDRESS Hagerstown Md	
24a. REC'D BY REGISTRAR Mar. 7. 1957		24b. REGISTRAR'S SIGNATURE Chas H. Bowers	

MARIANO STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU OF THE ARMY

RECEIVED

03428

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Williamsport</u>				c. LENGTH OF STAY IN 1b <u>4 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport RFD #2</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural- Williamsport</u>			
f. STREET ADDRESS <u>Williamsport RFD #2</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>T.</u> Last <u>Solomon</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 26, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin West Vbr.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>G. C. K. Solomon</u>				14. MOTHER'S MAIDEN NAME <u>Jane Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ella Solomon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Williamsport, Md.</u>				(County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>57</u> , to <u>8 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4 March</u> , 19 <u>57</u> , and that death occurred at <u>2 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Haak</u>				ADDRESS (Street, city or town, state) <u>280. Paxsonae, Williamsport, Md.</u>			
DATE SIGNED <u>8 March 57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Paul Haak M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred L. Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>March 8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 1

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03415

CERTIFICATE OF DEATH

Dr Hoffman

03425

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1234 Crescent Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WILLIAM STEEN		4. DATE OF DEATH Month March Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13 1897
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Darby Delaware Co Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Steen		14. MOTHER'S MAIDEN NAME Ella Eckert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 14-09-1127	
17. INFORMANT Elizabeth G. Steen		Address 1234 Crescent Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443 Hypertensive Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 5 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 1953, to March 21 1957, that I last saw the deceased alive on March 20 , 1957, and that death occurred at 2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lloyd A. Hoffman M.D. 214 N. Potomac St. Hagerstown Md. 3/24/57			
ACTUAL SIGNATURE Lloyd A. Hoffman		PHYSICIAN'S NAME (Type) Lloyd A. Hoffman	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/23/57	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Mar. 25, 1957		24b. REGISTRAR'S SIGNATURE Charles G. Bowser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of coroner	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Jan 15, 1957		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Date of report		21. Signature of informant		22. Signature of registrar		23. Signature of coroner		24. Signature of physician	
Jane Doe		Wife		1234 Main St.		Baltimore		Md.		21201		555-1234		Jan 16, 1957		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

MAR 27 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R#2 c. LENGTH OF STAY IN 1b 1 Yr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 142 Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ORVAS JESSE STOTELMYER				4. DATE OF DEATH Month March Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15 1869	
9. AGE (In years lost birthday) yrs. 87		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Wolfesville Fred Co	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Johathan Stotelmyer				14. MOTHER'S MAIDEN NAME Susan Bliokenstaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-6740		17. INFORMANT Hubert J. Stotelmyer Address 42 Broadway			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11, 1957 to March 7, 1957 that I last saw the deceased alive on March 6, 1957 and that death occurred at 5:11 P.M. from the causes and on the date stated above. ADDRESS (street, city or town, state) Boonsboro, Md. DATE SIGNED 3/7/57 ACTUAL SIGNATURE G. W. LeVan M.D. PHYSICIAN'S NAME (Type) G. W. LeVan M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/57		22c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		22d. LOCATION (City, town, or county) (State) Beaver Creek Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Address Hagerstown Md.				24a. REC'D BY REGISTRAR John A. Best		24b. REGISTRAR'S SIGNATURE John A. Best	

MAR 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANDREW K. COLLETT HOSPITAL MD.

DEPARTMENT OF HEALTH

STATE OF MARYLAND

MAR 8 1957

BUREAU V. 8

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03427
302

03416

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BOONSBORO</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. Co. HOSPITAL</u>				d. STREET ADDRESS <u>POTOMAC ST. EXTENDED</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WEBSTER WILSON STOTTLEMYER</u>				4. DATE OF DEATH Month Day Year <u>MARCH - 28 - 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 14 1878</u>	9. AGE (In years last birthday) <u>79-14 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>WOLFSVILLE FRED. CO. MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILSON STOTTLEMYER</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE SHUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>AUSTIN STOTTLEMYER SHARPSBURG MD. R.I</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Aneurysm internal iliac artery (lt)</u> <u>452X</u> DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis (old)</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>954X</u> Died under Na Pentothal Anesthetic							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 29 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>APR 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton Bowers</u>	

MEDICAL CERTIFICATION

81

2

2

PP

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 4 - 1957

RECEIVED

03417

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2/22/57</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Washington Co Hospital</u>				d. STREET ADDRESS <u>115 Myrtle Ave</u>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Alfred Carl Warner</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/3/02</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Waynesboro</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>A. Ritchie Warner</u>			
14. MOTHER'S MAIDEN NAME <u>Alvilda Eibee</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>171-28-5548</u>				17. INFORMANT <u>Mrs. A. Carl Warner</u> Address <u>Penna. 115 Myrtle Ave. Waynesboro,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - pyelonephritis - chronic</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Dysr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-26-</u> 1957, to <u>3-9-</u> 1957, that I last saw the deceased alive on <u>3-9-</u> 1957, and that death occurred at <u>5:31 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. S. Warden</u> M.D. <u>832 Potomac ave</u>				DATE SIGNED <u>3-9-57</u>			
PHYSICIAN'S NAME (Type) <u>J.G. WARDEN</u>				STATE <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Feltz & Sons Waynesboro, Pa.</u>				24. REC'D BY REGISTRAR <u>Mar. 12, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blanch Brownell</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03429

03418

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tenn.</u> b. COUNTY <u>Shelby</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Memphis 79X-3</u>			
c. LENGTH OF STAY IN 1b <u>4 Weeks</u>				d. STREET ADDRESS <u>1826 Lamar Pl.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isabelle</u> Middle <u>Lucille</u> Last <u>White</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1914</u>		9. AGE (In years last birthday) <u>42 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Quincy Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert N. Haldeman</u>			
14. MOTHER'S MAIDEN NAME <u>Bessie Sanders</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Richard Haldeman North Wales Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelitis chronic</u> <u>305X</u> DUE TO <u>E. Coli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubitus ulcers</u> DUE TO (c) <u>Picks Presenile Psychosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 months</u> <u>5 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 21, 1956</u> to <u>April 13, 1957</u> , that I last saw the deceased alive on <u>April 13, 1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D.				ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown</u> DATE SIGNED <u>3/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quincy</u>		22d. LOCATION (City, town, or county) (State) <u>Quincy, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter J. Love Waynesboro Pa.</u>				24a. REC'D BY REGISTRAR <u>Mar. 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shast Bowers</u>	

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, address, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03430

CERTIFICATE OF DEATH

Reg. Dist. No. 302

03430

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. 75X-3 b. COUNTY FRANKLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HAMILTON TWP.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MENNONITE CHURCH HOME		d. STREET ADDRESS 1034 LINCOLN WAY WEST	
3. NAME OF DECEASED (Type or print) First MARY Middle Alice Last WENGERT		4. DATE OF DEATH Month MARCH Day 17 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months + Days + Hours + Min. +	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) EDGEMONT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HOOVER		14. MOTHER'S MAIDEN NAME MARY STOFFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT ABRAM P. LEIGHT, Chambersburg, Pa		Address 1034 L.W.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH Time 20 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible orthostatic pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1. Month, Day, Year 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1956 to Mar 17, 1957 , that I last saw the deceased alive on June 15, 1956 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Dittus M.D.		ADDRESS (Street, city or town, state) 212 W. Washington St. Hagerstown, Md	
PHYSICIAN'S NAME (Type) Edward W. Dittus, Jr.		DATE SIGNED 3/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 19, 1957	22c. NAME OF CEMETERY OR CREMATORY NORLAND CEM.	22d. LOCATION (City, town, or county) (State) CHAMBERSBURG, PA.
23. FUNERAL DIRECTOR'S SIGNATURE SELLERS FUNERAL HOME CHAMBERSBURG, PA.		24. REC'D BY REGISTRAR Mar 22 1957	
24b. REGISTRAR'S SIGNATURE B. H. Bowers			

RECEIVED

BUREAU V. S.

MAR 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

03419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHUS RUBY WOLFKILL		4. DATE OF DEATH Month Day Year March 3 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Chambersburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Edmond Wolfkill		14. MOTHER'S MAIDEN NAME Emma Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-0198	
17. INFORMANT Mrs. Chas. W. Miller		Address 1940 Greenfield Road Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1957 to March 3, 1957, that I last saw the deceased alive on March 3, 1957, and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Henson Beachley M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Jack Henson Beachley M.D.		221 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 5, 1957	
		24b. REGISTRAR'S SIGNATURE Chas. Bowers	

RECEIVED

MAR 7 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18		CERTIFICATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF CEMETERY OFFICIAL	
21. SIGNATURE OF HEALTH OFFICIAL		22. SIGNATURE OF DISTRICT ATTORNEY	
23. SIGNATURE OF JUDGE		24. SIGNATURE OF CLERK	
25. SIGNATURE OF NOTARY		26. SIGNATURE OF SHERIFF	
27. SIGNATURE OF MARSHAL		28. SIGNATURE OF DEPUTY SHERIFF	
29. SIGNATURE OF DEPUTY MARSHAL		30. SIGNATURE OF DEPUTY CLERK	
31. SIGNATURE OF DEPUTY NOTARY		32. SIGNATURE OF DEPUTY SHERIFF	
33. SIGNATURE OF DEPUTY MARSHAL		34. SIGNATURE OF DEPUTY CLERK	
35. SIGNATURE OF DEPUTY NOTARY		36. SIGNATURE OF DEPUTY SHERIFF	
37. SIGNATURE OF DEPUTY MARSHAL		38. SIGNATURE OF DEPUTY CLERK	
39. SIGNATURE OF DEPUTY NOTARY		40. SIGNATURE OF DEPUTY SHERIFF	
41. SIGNATURE OF DEPUTY MARSHAL		42. SIGNATURE OF DEPUTY CLERK	
43. SIGNATURE OF DEPUTY NOTARY		44. SIGNATURE OF DEPUTY SHERIFF	
45. SIGNATURE OF DEPUTY MARSHAL		46. SIGNATURE OF DEPUTY CLERK	
47. SIGNATURE OF DEPUTY NOTARY		48. SIGNATURE OF DEPUTY SHERIFF	
49. SIGNATURE OF DEPUTY MARSHAL		50. SIGNATURE OF DEPUTY CLERK	
51. SIGNATURE OF DEPUTY NOTARY		52. SIGNATURE OF DEPUTY SHERIFF	
53. SIGNATURE OF DEPUTY MARSHAL		54. SIGNATURE OF DEPUTY CLERK	
55. SIGNATURE OF DEPUTY NOTARY		56. SIGNATURE OF DEPUTY SHERIFF	
57. SIGNATURE OF DEPUTY MARSHAL		58. SIGNATURE OF DEPUTY CLERK	
59. SIGNATURE OF DEPUTY NOTARY		60. SIGNATURE OF DEPUTY SHERIFF	
61. SIGNATURE OF DEPUTY MARSHAL		62. SIGNATURE OF DEPUTY CLERK	
63. SIGNATURE OF DEPUTY NOTARY		64. SIGNATURE OF DEPUTY SHERIFF	
65. SIGNATURE OF DEPUTY MARSHAL		66. SIGNATURE OF DEPUTY CLERK	
67. SIGNATURE OF DEPUTY NOTARY		68. SIGNATURE OF DEPUTY SHERIFF	
69. SIGNATURE OF DEPUTY MARSHAL		70. SIGNATURE OF DEPUTY CLERK	
71. SIGNATURE OF DEPUTY NOTARY		72. SIGNATURE OF DEPUTY SHERIFF	
73. SIGNATURE OF DEPUTY MARSHAL		74. SIGNATURE OF DEPUTY CLERK	
75. SIGNATURE OF DEPUTY NOTARY		76. SIGNATURE OF DEPUTY SHERIFF	
77. SIGNATURE OF DEPUTY MARSHAL		78. SIGNATURE OF DEPUTY CLERK	
79. SIGNATURE OF DEPUTY NOTARY		80. SIGNATURE OF DEPUTY SHERIFF	
81. SIGNATURE OF DEPUTY MARSHAL		82. SIGNATURE OF DEPUTY CLERK	
83. SIGNATURE OF DEPUTY NOTARY		84. SIGNATURE OF DEPUTY SHERIFF	
85. SIGNATURE OF DEPUTY MARSHAL		86. SIGNATURE OF DEPUTY CLERK	
87. SIGNATURE OF DEPUTY NOTARY		88. SIGNATURE OF DEPUTY SHERIFF	
89. SIGNATURE OF DEPUTY MARSHAL		90. SIGNATURE OF DEPUTY CLERK	
91. SIGNATURE OF DEPUTY NOTARY		92. SIGNATURE OF DEPUTY SHERIFF	
93. SIGNATURE OF DEPUTY MARSHAL		94. SIGNATURE OF DEPUTY CLERK	
95. SIGNATURE OF DEPUTY NOTARY		96. SIGNATURE OF DEPUTY SHERIFF	
97. SIGNATURE OF DEPUTY MARSHAL		98. SIGNATURE OF DEPUTY CLERK	
99. SIGNATURE OF DEPUTY NOTARY		100. SIGNATURE OF DEPUTY SHERIFF	

03420

CERTIFICATE OF DEATH

03432

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>22 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 East Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY WOODYATT</u>				4. DATE OF DEATH Month Day Year <u>March 29 19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 22, 1871</u>		9. AGE (In years last birthday) <u>85 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>5 7</u>	IF UNDER 24 HRS. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Manufacture</u>		11. BIRTHPLACE (State or foreign country) <u>Staffordshire, Eng.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur Woodyatt</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Priest</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-1994</u>		17. INFORMANT Address <u>Mrs. Maly L. Woodyatt Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u> <u>3 1/2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus, mild</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1957</u> , to <u>March 29, 1957</u> , that I last saw the deceased alive on <u>March 29, 1957</u> , and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Building</u> DATE SIGNED <u>3-29-57</u> ACTUAL SIGNATURE <u>William T. Leyman</u> M.D. PHYSICIAN'S NAME (Type) <u>William T. Leyman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royce</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>April 1, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>			

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH
 CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		12-1-22		ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CLOCK REPAIRER		CLOCK REPAIRER		ARMY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		POST-MORTEM	
4-4-68		MOBILE, ALABAMA		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		2 WEEKS		HOSPITAL		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHIEF OF BUREAU	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 APR 3 1968
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03421
CERTIFICATE OF DEATH

03433

Reg. Dist. No. **B02**

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 734 WASHINGTON AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First DAVID Middle CONRAD Last YOUNGBLOOD				4. DATE OF DEATH Month MARCH Day 6 Year 19 57									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/57		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD H. YOUNGBLOOD				14. MOTHER'S MAIDEN NAME JANET JOHNSON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. CONRAD H. YOUNGBLOOD				Address HAGERSTOWN MD.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Macoviscidosis 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital cystic disease of pancreas DUE TO (c) 4 days				INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 2 March, 19 57 , to 6 March, 19 57 that I last saw the deceased alive on 6 March, 19 57 , and that death occurred at 4:40 PM , from the causes and on the date stated above.													
ACTUAL SIGNATURE E. Edgar Houchard M.D.				ADDRESS (Street, city or town, state) Hagerstown, Md.				DATE SIGNED 3/7/57					
PHYSICIAN'S NAME (Type) E. Edgar Houchard													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/8/57		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.				22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Mar. 9. 1957		24b. REGISTRAR'S SIGNATURE E. Edgar Houchard			

MAR 12 1957

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